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	17E630	A. BUILDING _____ B. WING _____	C 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANTHONY COMMUNITY CARE CENTER	212 N 5TH AVE ANTHONY, KS 67003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation 57166/XWCU11.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility census totaled 32 residents, with 3 sampled. Based on observation, interview and record review the facility failed to ensure the revision of the care plan related to additional interventions to prevent accidents for 2 of 3 sampled residents (#1 and #3). Findings included:	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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- Resident #3's Admission MDS (Minimum Data Set) dated 8-15-11 identified the resident with a BIMS (Brief Interview of Mental Status) of 6, which indicated severe impairment of the resident's cognitive status, feeling down or depressed and bad about him/herself. The MDS identified no behavioral symptoms over the two weeks previous to the completion of the MDS. The MDS identified the resident required supervision of one staff for all activities of daily living (ADL's) with the exception of walking in the room for which the resident required no assistance. The MDS identified the resident was not steady but able to stabilize self when moving from a seated to standing position, turning around and moving on and off the toilet. The MDS identified the resident had pain, but not within the five days previous to completion of the MDS. The MDS identified no fall for the resident.

The quarterly MDS dated 2-2-12 identified the resident with a BIMS of 4, or severely cognitively impaired. The MDS identified the resident with fluctuating periods of disorganized thinking. The MDS also identified the resident with delusions 4 to 6 days of the look behind period (the 7 days previous to completion of the MDS data collection), but not daily. The MDS identified the resident with wandering behavior 4 to 6 days of the look back period. The MDS identified the resident was independent with all ADL's except for dressing and personal hygiene for which the resident required the supervision of one person. The MDS showed the resident required physical help for bathing. The MDS identified the resident was not steady, but able to stabilize without human assist when moving from a seated to

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F 280	Continued From page 2	F 280		

standing position and turning around and moving on and off the toilet. The MDS identified the resident with the presence of pain, but not in the previous 5 days. The MDS showed the resident had not had any falls.

The CAA (Care Area Assessment) for falls, dated 8-15-11, identified the resident with a potential for falls related to balance problems, medications, postural hypotension, anemia, cognitive loss, dementia, signs and symptoms of depression and a history of impulsivity and poor safety awareness.

Review of the care plan last reviewed on 2-12-12 lacked any intervention related to the use of a wanderguard to alert staff if the resident left the building. Administrative Staff E confirmed the lack of such on 6-5-12 at 1:25 p.m. The care plan review also revealed the lack of any care plan intervention indicating the resident required supervision while on the outdoor patio. Staff E also confirmed the lack of an intervention on the care plan that would require staff to supervise the resident while on the outdoor patio.

Review of nursing notes dated 4-10-12 at 10:00 a.m. noted a late entry for 4-7-12. The entry noted the resident had some "abnormal behaviors" and had repeated over and over that he/she had gone to the store the previous evening and someone stole his/her car and now the cops were after him/her.

On 4-10-12 at 1:00 p.m. nursing notes showed staff placed a wanderguard on the resident's left ankle, for safety.

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On 4-18-12 at 1:00 p.m. the nurse noted the resident was in another resident's room and refused to move. The nurse noted the resident was confused and seemed distrusting of the staff, feeling staff had called him/her a liar and blamed him/her for hurting someone.

A nursing note on 4-25-12 at 1:45 p.m. noted the resident had increased behaviors, had gotten into the roommates things, which upset the roommate and then angered resident #3. This same note indicated the resident had headaches recently and had delusions and hallucinations and felt someone he/she did not know was in his/her room. The note also stated the resident wandered about the facility more and looked for support from staff.

A nursing note dated 5-1-12 at 4:00 p.m. documented the resident went to the nursing desk at 10:40 a.m. and was crying. The resident reported he/she was on the back patio and tried to jump the fence to get to music lessons and thought he/she broke his/her arm and shoulder. The nurse assessed the resident's injuries and sent the resident to the emergency department at the hospital. The note continued that the resident returned to the facility at 3:00 p.m. Family reported to the staff that the resident had a crack in his/her right wrist.

Interview on 6-5-12 at 1:30 p.m. with direct care staff A revealed resident #3 was free to come and go onto the patio whenever he/she wanted. Staff A said resident #3 did not need anyone to go out onto the patio with him/her. Staff A said someone checked on the residents on the patio every thirty minutes or so. The staff said everyone just

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looked out on the patio when they went by to go to the dining room or kitchen area. Staff A said the direct care staff also told each other someone was out on the patio, however no staff were assigned to supervise the patio. Staff A said care plans for the direct care staff were kept on the back of the door to each resident's bathroom. Staff A said he/she was not aware of any changes to resident #3's care after the accident on the patio.

Interview with direct care staff B on 6-5-12 at 3:00 p.m. revealed resident #3 was "just out there" and sometimes said things that were not true. Staff B said he/she was in the area of the patio door when resident #3 came in on 5-11-12 and said he/she had hurt him/herself when climbing the fence to get to the busload of kids. Staff B said the resident also told a resident's visitor he/she was hurt before going
on to the nurses desk and telling Licensed Staff D he/she was hurt.

Interview with Licensed Staff D on 6-5-12 at 1:48 p.m. revealed he/she put a wanderguard on resident #3 for safety reasons because he/she was having more delusions and was more restless. Staff D expressed concern that there was a highway so close to the facility.

The facility failed to revise this resident's care plan to address the safety needs and prevention of accidents related to increased hallucinations/delusions and wandering for resident #3.

- Review of resident #1's Admission MDS dated 12-21-11 revealed the resident had a BIMS (Brief

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Interview of Mental Status) of 2, indicating severe cognitive impairment. The MDS identified the resident had inattention that came and went, with changes in severity. The resident also displayed disorganized thinking, with changes in the severity of the disorganized thinking. The MDS identified the resident to have hallucinations and delusions. The MDS also noted the resident had behavioral symptoms that significantly interfered with resident ' s care and put others at significant risk for physical injury. The MDS identified the resident required extensive assistance of two persons for all ADL's (Activities of Daily Living) except eating, and personal hygiene which required extensive assistance of one person. The MDS identified the resident with unsteadiness and the inability to stabilize without human assistance for moving from a seated to standing position, walking, turning around, moving on and off the toilet and surface-to-surface transfers. The MDS identified the resident was frequently incontinent of urine. The MDS identified the resident with an anxiety disorder and mild occasional pain. The MDS showed the resident had a fall since admission with no injury.

Review of the quarterly MDS dated 3-21-12 revealed the resident with a BIMS of 0, or severe cognitive impairment. The resident's inattention and disorganized thinking remained the same as the admission assessment. The resident continued to have hallucinations and delusions. The MDS noted an increased need for assistance for ADL's. The MDS identified the resident required extensive assistance of 2 persons for bed mobility, transfers, walking in room and corridor, dressing, toilet use, personal hygiene and was totally dependent on staff for locomotion

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on and off the unit and required limited assist of 1 for eating.

The Cognitive CAA (Care Area Assessment) dated 12-9-11 identified the resident had Alzheimer's Dementia with behavioral disturbances, a short attention span, confusion with forgetfulness, disorientation and lived in the past at times through hallucinations and delusion. The Fall CAA dated 12-9-11 identified the resident with a history of falls, poor coordination, poor balance, unsteady gait, awkward crisscrossing steps at times, incontinent, cognitive loss and hallucinations/delusions.

The facility last reviewed the care plan on 3-27-12. Care plan interventions related to prevention of falls included: 1-2 staff to provide weight bearing assistance for transfers, 1-2 staff provide weight bearing assistance for ambulation with a gait belt and walker at times or 2 hand held assist as sometimes he/she does better that way, anticipate resident's needs, resident does not use call light, make frequent visual checks for safety, do not close the door to room. Additions to the care plan included: on 4-23-12, lock wheelchair brakes and initiation of the use of a body alarm when up in the wheelchair, body alarm on when in room alone, check to ensure it is in working order before leaving the room, an addition on 4-25-12 to educate staff on mental status, assist resident to toilet per schedule and when attempting to climb out of his/her chair, do not ask if he/she needs to toilet due to diminished mental capacity and perception of needing to void/have stools.

The nurse Assistant Flowsheet identified as the

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careplan for the nurses aides noted the following: the resident had a toileting schedule, body alarm on when in room alone and check to ensure it is in working order before leaving the room, make sure non skid socks or shoes are worn for all transfers and ambulation, and walk to dine for each meal.

Review of the nursing notes dated 4-19-12 at 4:40 p.m. identified staff found the resident on the floor between the pedals of the wheelchair. The notes identified the resident had an approximate 1.5 cm (centimeter) laceration to the right upper lip and a less than ½ cm skin tear to the right back of forearm, which staff treated at the facility. Review of the care plan found no revisions related to this fall. Interview with Administrative Staff E on 6-6-12 at 10:23 a.m. revealed the resident was getting up out of the recliner in his/her room and the wheelchair was next to the recliner and the resident fell between the wheelchair pedals. Staff E confirmed the lack of any investigation of cause of the fall and identification of interventions to try and prevent further falls of this nature.

Review of nursing notes dated 5-5-12 at 1:30 p.m. revealed the resident fell at 12:20 p.m. in the dining room. Two nurse aides were noted to have witnessed the fall and attempted to reach the resident before he/she fell, but could not. The resident's body alarm did sound when the resident stood. The resident received a laceration above the right eye and was taken to the emergency department. The resident received 7 stitches to close the laceration above his/her eye. Review of the care plan revealed staff made no revision related to attempts to

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prevent further falls of this nature. Interview with Administrative Staff E on 6-6-12 at 10:42 am. revealed the resident was no longer allowed to sit at the table alone. Staff E said otherwise the staff sat the resident at the bar where the staff were closer and could supervise the resident more closely.

Nursing notes on 5-29-12 at 10:00 a.m. revealed the housekeeper heard an alarm sounding in the living room and summoned a licensed nurse. Staff found the resident lying on his/her left side. The alarm was sounding and his wheelchair had the front right wheel on top of another chair in his/her room and the resident was under the wheelchair. The resident complained of pain to his/her left shoulder and was sent to the emergency department, however he/she needed no treatment. Interview with Administrative Staff E on 6-6-12 at 10:38 a.m. revealed the staff had brought the resident to the living room to wait for breakfast and he/she attempted to get out of the wheelchair. Staff E said the direct care staff woke the resident early and brought the resident to the living room and left the resident sitting in the living room waiting for breakfast. Staff E said he/she had instructed staff not to wake the resident and bring him/her out to dining room after the resident woke, so he/she would not try to get up and fall. Staff E confirmed the staff had not revised the care plan with this intervention as of the 6-6-12 interview.

Interview with Administrative Staff E on 6-6-12 at 10:53 a.m. revealed he/she recognized the fall investigations did not include the immediate environmental factors possibly related to the cause of the fall, or interventions to try and

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F 280	Continued From page 9 prevent similar falls. Observation on 6-6-12 at 11:52 a.m. revealed Direct Care Staff H and Direct Care Staff I assisted the resident with toileting then walked the resident to the dining room. The direct care staff sat the resident at a table across from the bar. No one else sat at the table. Interview with Administrative Staff E on 6-6-12 at 12:00 p.m. confirmed the staff were to sit the resident at the bar for closer supervision and not at the table away from staff's immediate supervision. Interview with Direct Care Staff H at 10:20 a.m. on 6-5-12 revealed the staff should check on the resident frequently. Staff H said the resident can move really fast and even though staff place a body alarm on him/her, it is usually already going off and the staff cannot get to the resident before he/she falls. Interview with Direct Care Staff J on 6-6-12 at 3:55 p.m. revealed the staff try to let this resident sleep in later in the morning, because staff think maybe the resident just got tired, fell asleep and fell out of his/her chair. Interview with Administrative Staff E on 6-6-12 at 11:00 a.m. revealed he/she sees the resident trying to do more on his/her own, and staff just need to be educated more about what to do when the resident is more active and what to do when the resident is more sleepy to prevent falls. The facility failed to revise the care plan to reflect additional interventions to prevent further accidents for resident #3.	F 280		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=G	Continued From page 10 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility census totaled 32 residents, with 3 sampled. Based on observation, interview and record review the facility failed to ensure the provision of adequate supervision and assistive devices to prevent accidents for 2 of 3 sampled residents (#1 and #3). Resident #3 sustained a fracture while unsupervised in an outdoor courtyard area. Findings included: - Resident #3's Admission MDS (Minimum Data Set) dated 8-15-11 identified the resident with a BIMS (Brief Interview of Mental Status) of 6, which indicated severe impairment of the resident's cognitive status, feeling down or depressed and bad about him/herself. The MDS identified no behavioral symptoms over the two weeks previous to the completion of the MDS. The MDS identified the resident required supervision of one staff for all activities of daily living (ADL's) with the exception of walking in the room for which the resident required no assistance. The MDS identified the resident was not steady but able to stabilize self when moving	F 323		

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F 323	Continued From page 11	F 323		

from a seated to standing position, turning around and moving on and off the toilet. The MDS identified the resident had pain, but not within the five days previous to completion of the MDS. The MDS identified no fall for the resident.

The quarterly MDS dated 2-2-12 identified the resident with a BIMS of 4, or severely cognitively impaired. The MDS identified the resident with fluctuating periods of disorganized thinking. The MDS also identified the resident with delusions 4 to 6 days of the look back period (the 7 days previous to completion of the MDS data collection), but not daily. The MDS identified the resident with wandering behavior 4 to 6 days of the look back period. The MDS identified the resident was independent with all ADL's except for dressing and personal hygiene for which the resident required the supervision of one person. The MDS showed the resident required physical help for bathing. The MDS identified the resident was not steady, but able to stabilize without human assist when moving from a seated to standing position and turning around and moving on and off the toilet. The MDS identified the resident with the presence of pain, but not in the previous 5 days. The MDS showed the resident had not had any falls.

The CAA (Care Area Assessment) for falls, dated 8-15-11, identified the resident with a potential for falls related to balance problems, medications, postural hypotension, anemia, cognitive loss, dementia, signs and symptoms of depression and a history of impulsivity and poor safety awareness.

Review of the care plan last reviewed on 2-12-12

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lacked any intervention related to the use of a wanderguard to alert staff if the resident left the building. Administrative Staff E confirmed the lack of such on 6-5-12 at 1:25 p.m. The care plan review also revealed the lack of any care plan intervention indicating the resident required supervision while on the outdoor patio. Staff E also confirmed the lack of an intervention on the care plan that would require staff to supervise the resident while on the outdoor patio.

Review of nursing notes dated 4-10-12 at 10:00 a.m. noted a late entry for 4-7-12. The entry noted the resident had some "abnormal behaviors" and had repeated over and over that he/she had gone to the store the previous evening and someone stole his/her car and now the cops were after him/her.

On 4-10-12 at 1:00 p.m. nursing notes showed staff placed a wanderguard on the resident's left ankle, for safety.

On 4-18-12 at 1:00 p.m. the nurse noted the resident was in another resident's room and refused to move. The nurse noted the resident was confused and seemed distrusting of the staff, feeling staff had called him/her a liar and blamed him/her for hurting someone.

A nursing note on 4-25-12 at 1:45 p.m. noted the resident had increased behaviors, had gotten into the roommates things, which upset the roommate and then angered resident #3. This same note indicated the resident had headaches recently and had delusions and hallucinations and felt someone he/she did not know was in his/her room. The note also stated the resident

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wandered about the facility more and looked for support from staff. The nurse obtained a physician's order on 4-25-12 for one milligram of Valium to attempt to calm the resident. The staff gave the Valium at 4:40 p.m. and at 5:10 p.m. the resident went to the front door opened it and walked out. Staff noted the resident had an unsteady gait and held on to the walls for support. The staff also noted the resident had displayed unsteadiness prior to receiving the Valium.

A nursing note on 5-1-12 at 8:50 a.m. revealed the resident was admitted to a behavioral health unit. The next nursing note was 5/10/12 at 7:00 p.m. and noted the resident had ambulated up and down the hall visiting with other residents, and was cooperative with staff.

A nursing note dated 5-1-12 at 4:00 p.m. documented the resident went to the nursing desk at 10:40 a.m. and was crying. The resident reported he/she was on the back patio and tried to jump the fence to get to music lessons and thought he/she broke his/her arm and shoulder. The nurse assessed the resident's injuries and sent the resident to the emergency department at the hospital. The note continued that the resident returned to the facility at 3:00 p.m. Family reported to the staff that the resident had a crack in his/her right wrist.

Interview on 6-5-12 at 1:30 p.m. with direct care staff A revealed he/she was not here at the time resident #3 attempted to jump the fence. Staff A said resident #3 was free to come and go onto the patio whenever he/she wanted. Staff A said resident #3 did not need anyone to go out onto the patio with him/her. Staff A said someone

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checked on the residents on the patio every thirty minutes or so. The staff said everyone just looked out on the patio when they went by to go to the dining room or kitchen area. Staff A said the direct care staff also told each other someone was out on the patio, however no staff were assigned to supervise the patio. Staff A said care plans for the direct care staff were kept on the back of the door to each resident's bathroom. Staff A said he/she was not aware of any changes to resident #3's care after the accident on the patio.

Interview with direct care staff B on 6-5-12 at 3:00 p.m. revealed resident #3 was "just out there" and sometimes said things that were not true. Staff B said he/she was in the area of the patio door when resident #3 came in on 5-11-12 and said he/she had hurt him/herself when climbing the fence to get to the bus load of kids. Staff B said the resident also told a resident's visitor he/she was hurt before going on to the nurses desk and telling Licensed Staff D he/she was hurt.

Interview with Licensed Staff D on 6-5-12 at 1:48 p.m. revealed he/she put a wanderguard on resident #3 for safety reasons because he/she was having more delusions and was more restless. Staff D expressed concern that there was a highway so close to the facility.

Interview with Licensed Staff C on 6-5-12 at 1:50 p.m. revealed the patio, " fenced courtyard " was considered a safe area for residents prior to resident #3's incident. Staff C identified the patio as a place residents were allowed without supervision, except for a select few who were care planned as such and required supervision to

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F 323	Continued From page 15 go out. Interview with Licensed Staff D on 6-5-12 at 2:45 p.m. revealed the resident did present to the desk on 5-11-12 and report he/she had tried to jump the fence to get to his/her music lessons and he/she had broken his/her arm. Interview with Administrative Staff E on 6-5-12 at 1:26 p.m. revealed resident #3 had a wanderguard but he/she was not sure why. Staff E said the residents with a wanderguard could go out onto the patio because the area was fenced. Staff E said at the time of the incident there were no staff on the outdoor patio, so no one was really sure what happened. Staff E said the resident told different staff that he/she was going to music lessons, he/she was going to get a bus load of kids, and he/she was going to get his/her car. Interview with Administrative Staff E on 6-5-12 at 1:45 p.m. revealed the facility lacked a policy related to wanderguards. Further interview with staff E revealed he/she would not consider the resident at risk in the courtyard when he/she displayed an increase in delusions and hallucinations, Staff E said the resident had just returned to the facility the day before the accident occurred. Staff E said the resident had gone to a behavioral health unit for treatment of delusions and hallucinations, however upon return of the resident Staff E said even though the resident visited with other residents and staff and appeared calm, the resident just didn't seem like him/herself. Interview with Consultant Staff F on 6-6-12 at	F 323		

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4:10 p.m. revealed he/she did not see the resident in the emergency department when this fall happened but it was his/her understanding the resident had a "psychotic break" and attempted to go over the fence at the facility and fell. Staff F said he/she was of the understanding the fracture occurred as a result of the fall. Staff F confirmed the resident did not have any disease process that would cause a spontaneous fracture. Staff F said the resident sustained a distal radius fracture and a humeral head fracture.

Policies related to the use of wanderguards and monitoring of residents wearing wanderguards and criteria for residents to go on the patio unsupervised were requested from Administrative Staff E on 6-5-12 at 1:45 p.m. Staff E looked, but said he/she found no policy for either.

The facility failed to ensure supervision of a resident staff had identified with increased delusions and hallucinations and an increase in wandering. The resident sustained a fracture of the distal radius and humeral head while attempting to jump the fence of the patio to get to an event he/she perceived, but was not real.

- Review of resident #1's Admission MDS (Minimum Data Set) dated 12-21-11 revealed the resident had a BIMS (Brief Interview of Mental Status) of 2, indicating severe cognitive impairment. The MDS identified the resident had inattention that came and went, with changes in severity. The resident also displayed disorganized thinking, with changes in the severity of the disorganized thinking. The MDS identified the resident to have hallucinations and delusions. The MDS also noted the resident had

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behavioral symptoms that significantly interfered with the resident's care and put others at significant risk for physical injury. The MDS identified the resident required extensive assistance of two persons for all ADL's (Activities of Daily Living) except eating, and personal hygiene which required extensive assistance of one person. The MDS identified the resident with unsteadiness and the inability to stabilize without human assistance for moving from a seated to standing position, walking, turning around, moving on and off the toilet and surface-to-surface transfers. The MDS identified the resident was frequently incontinent of urine. The MDS identified the resident with an anxiety disorder and mild occasional pain. The MDS showed the resident had a fall since admission with no injury.

Review of the quarterly MDS dated 3-21-12 revealed the resident with a BIMS of 0, or severe cognitive impairment. The resident's inattention and disorganized thinking remained the same as the admission assessment. The resident continued to have hallucinations and delusions. The MDS noted an increased need for assistance for ADL's. The MDS identified the resident required extensive assistance of 2 persons for bed mobility, transfers, walking in room and corridor, dressing, toilet use, personal hygiene and was totally dependent on staff for locomotion on and off the unit and required limited assist of 1 for eating.

The Cognitive CAA (Care Area Assessment) dated 12-9-11 identified the resident had Alzheimer's Dementia with behavioral disturbances, a short attention span, confusion

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with forgetfulness, disorientation and lived in the past at times through hallucinations and delusion. The Fall CAA dated 12-9-11 identified the resident with a history of falls, poor coordination, poor balance, unsteady gait, awkward crisscrossing steps at times, incontinent, cognitive loss and hallucinations/delusions.

The facility last reviewed the care plan on 3-27-12. Care plan interventions related to prevention of falls included: 1-2 staff to provide weight bearing assistance for transfers, 1-2 staff to provide weight bearing assistance for ambulation with a gait belt and walker at times or 2 hand held assist as sometimes he/she does better that way, anticipate resident's needs, resident does not use call light, make frequent visual checks for safety, do not close the door to his/her room. Additions to the care plan included: on 4-23-12, lock wheelchair brakes and initiation of the use of a body alarm when up in the wheelchair, body alarm on when in room alone, check to ensure it is in working order before leaving the room, an addition on 4-25-12 to educate staff on mental status, assist resident to toilet per schedule and when attempting to climb out of his/her chair, do not ask if he/she needs to toilet due to diminished mental capacity and perception of needing to void/have stools.

The nurse Assistant Flowsheet identified as the care plan for the nurses aides noted the following: the resident had a toileting schedule, body alarm on when in his/her room alone and check to ensure it is in working order before leaving his/her room, make sure non skid socks or shoes are worn for all transfers and ambulation, and walk to dine for each meal.

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Review of the nursing notes dated 4-19-12 at 4:40 p.m. identified staff found the resident on the floor between the pedals of the wheelchair. The notes identified the resident had an approximate 1.5 cm (centimeter) laceration to the right upper lip and a less than ½ cm skin tear to the back of the right forearm, which staff treated at the facility. Review of the care plan found no revisions related to this fall.
Interview with Administrative Staff E on 6-6-12 at 10:23 a.m. revealed the resident was getting up out of the recliner in his/her room and the wheelchair was next to the recliner and the resident fell between the wheelchair pedals. Staff E confirmed the lack of any investigation of cause of the fall and identification of interventions to try and prevent further falls of this nature.

Nursing notes dated 4-23-12 at 6:15 p.m. documented the staff found the resident on the living room floor on his/her back. Review of the fall investigation dated 4-23-12 identified the resident attempted to stand without assist and fell. The investigation also noted Direct Care Staff L identified the wheelchair brakes were weak. Interview with Administrative Staff E on 6-6-12 at 10:40 a.m. revealed they did replace the resident's entire wheelchair. Review of the care plan revealed staff initiated the use of a body alarm after the fall.

Review of nursing notes dated 5-5-12 at 1:30 p.m. revealed the resident fell at 12:20 p.m. in the dining room. Two nurse aides were noted to have witnessed the fall and attempted to reach the resident before he/she fell, but could not. The resident's body alarm did sound when the

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resident stood. The resident received a laceration above the right eye and was taken to the emergency department. The resident received 7 stitches to close the laceration above his/her eye. Review of the care plan revealed staff made no revision related to attempts to prevent further falls of this nature. Interview with Administrative Staff E on 6-6-12 at 10:42 am. revealed the resident was no longer allowed to sit at the table alone. Staff E said otherwise the staff sat the resident at the bar where the staff were closer and could supervise the resident more closely.

Review of the nursing notes dated 5-25-12 at 6:05 p.m. revealed staff found the resident on the floor next to the recliner in his/her room at 5:05 p.m. The staff assessed the resident with a small abrasion to his/her right shoulder. Review of the fall investigation dated 5-25-12 revealed the staff found the resident lying between his/her recliner and the window wall. Staff noted the lack of a body alarm in place at the time of the resident's fall. Interview on 6-6-12 at 10:55 a.m. with Licensed Staff C revealed there was no body alarm even in the resident's room at the time of the fall. Staff C said he/she immediately educated the direct care staff that they must check the alarm at shift change to ensure it functioned properly and also check the functioning at the time of placement of the alarm.

Nursing notes on 5-29-12 at 10:00 a.m. revealed the housekeeper heard an alarm sounding in the living room and summoned a licensed nurse. Staff found the resident lying on his/her left side. The alarm was sounding and his wheelchair had the front right wheel on top of another chair in

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his/her room and the resident was under the wheelchair. The resident complained of pain to his/her left shoulder and was sent to the emergency department, however he/she needed no treatment. Interview with Administrative Staff E on 6-6-12 at 10:38 a.m. revealed the staff had brought the resident to the living room to wait for breakfast and he/she attempted to get out of the wheelchair. Staff E said the direct care staff woke the resident early and brought the resident to the living room and left the resident sitting in the living room waiting for breakfast. Staff E said he/she had instructed staff not to wake the resident if still sleeping. Staff E confirmed the staff had not revised the care plan with this intervention as of the 6-6-12 interview.

Interview with Administrative Staff E on 6-6-12 at 10:53 a.m. revealed he/she recognized the fall investigations did not include the immediate environmental factors possibly related to the cause of the fall, or interventions to try and prevent similar falls.

Observation on 6-6-12 at 11:52 a.m. revealed Direct Care Staff H and Direct Care Staff I assisted the resident with toileting then walked the resident to the dining room. The direct care staff sat the resident at a table across from the bar. No one else sat at the table. Interview with Administrative Staff E on 6-6-12 at 12:00 p.m. confirmed the staff were to sit the resident at the bar for closer supervision and not at the table away from staff's immediate supervision.

Interview with Direct Care Staff H on 6-5-12 at 10:20 a.m. revealed the staff should check on the resident frequently. Staff H said the resident can

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move really fast and even though staff place a body alarm on him/her, it is usually already going off and the staff cannot get to the resident before he/she falls.

Interview with Direct Care Staff J on 6-6-12 at 3:55 p.m. revealed the staff try to let this resident sleep in later in the morning, because staff think maybe the resident just got tired, fell asleep and fell out of his/her chair. Staff J said the staff try to "entertain" the resident more by visiting with the resident about particular interests. Staff J said they also try to toilet the resident every two hours.

Interview with Administrative Staff E on 6-6-12 at 11:00 a.m. revealed he/she sees the resident trying to do more on his/her own, and staff just need to be educated more about what to do when the resident is more active and what to do when the resident is more sleepy to prevent falls.

The facility failed to consistently identify causal factors of resdient #1's falls, then develop and implement interventions in an effort to prevent falls. This resident did sustain multiple falls with one fall resulting in a laceration of the forehead that required seven sutures to close it.